March 9, 2012

Mr. Gary Cohen
Director, CCIIO Office of Oversight
Centers for Medicare & Medicaid Services (CMS)
U.S. Department of Health and Human Services
Bethesda, MD 20814

Re: State-Specific Thresholds for Rate Review

Mr. Cohen:

We are writing on behalf of health care consumers to comment on Discussion Draft #2, State-Specific Thresholds – Recommended Approach, shared by HHS on March 2, 2012.

Rate review is critically important to consumers who have in the past faced premium rate increases that exceeded medical inflation and far outpaced wage growth. The temporary 10 percent threshold for a rate that is subject to review was an expedient benchmark for rate review enforcement under § 2794 of the Public Health Service Act, as added by § 1002 of the Affordable Care Act. However, more consideration should be given to how this threshold is set in future years in the states.

The Discussion Draft proposes a process in which the default "subject to review" threshold of 10 percent would remain in effect and states could request a lower or higher threshold based on certain analytical or policy factors. Generally, we agree with the idea that states should initiate and apply for a change to the current threshold, but we urge you to adopt the following changes to the proposed process.

HHS Should Consider Lowering the Default Threshold

In most recent years, average premium increases have been significantly lower than 10 percent. For example, the CMS Office of the Actuary reports that in 2009, per enrollee private health insurance premiums increased 4.7 percent and per enrollee private health insurance spending on benefits increased 6.8 percent[1]; in 2007, per enrollee premium increases were even lower (3.9 percent).[2] Medical costs, the primary driver of rate increases, grew at historically low levels in 2010.[3] Thus, the 10 percent threshold may be excessive in relation to recent national or state premium trends. For consumers in states that generally have more efficient medical spending, a 10 percent threshold may be particularly high.

Moreover, if consumers can be subjected to annual 10 percent rate increases, without administrative scrutiny, health plans will have no incentive to bend the cost curve. We recommend that HHS carefully review the current 10 percent threshold and possibly lower it in light of recent and emerging trends.

Require States to Use a Transparent Process With Consumer Input When Setting a Proposed Threshold

[1] Anne Martin, et al., Recession Contributes to Slowest Annual Rate of Increase in Health Spending In Five Decades, *Health Affairs*, January 2011, vol. 30 no. 1, pp 11-22.
[2] National Health Expenditures Historical Tables, Table 13, Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group.
[3] Anne Martin, et al., supra. note 1.

The Discussion Draft notes that among the subjective factors a state may consider in changing its threshold are the "effectiveness of the State's public comment process" and "a large volume of public comments about the need to move the threshold," but the proposal itself has no requirement for states to accept public comments related to setting the threshold for review. Consumer groups are more likely to generate comments on proposals for setting state thresholds than in individual rate review determinations because the time-intensity of the individual rate review process and the inability to access certain plan information that is considered to be a trade secret may discourage participation in individual rate reviews.

Consumers are, of course, those most directly affected by premium increases and the § 2794 process to date has been designed to involve and inform consumers. It would be highly anomalous to allow states to establish rate-review thresholds with no input from consumers. We urge you to require that states include consumer input in an open process that is documented on the record that is submitted to HHS when a state applies for a change to the threshold.

HHS Should Independently Evaluate Available Data to Determine Thresholds and Should Refine the Factors for Consideration

In general, we are concerned that the adoption of a state-initiated process will mean that many states – due to recalcitrance, powerful insurer interests, or lack of capacity – will unnecessarily apply to raise or will never voluntarily lower the threshold. In addition to possibly lowering the default threshold, HHS must carefully and independently consider state-specific factors through this state-initiated process.

Rate review is critically important in keeping insurers honest about health care cost increases and in setting a higher standard for cost containment. As we have seen in the medical loss ratio adjustment applications, state insurance departments often rely too heavily on insurers to develop evidence supporting a need to change national standards. If HHS adopts another state-initiated process, it must ensure that all relevant data is considered, even beyond the information submitted by the state. HHS should independently investigate state-specific factors in deciding whether to change a threshold. We also urge HHS to establish state-specific thresholds through a transparent process.

Further, we have concerns about some of the factors proposed as having relevance to a state-specific threshold. For example, a state might use the fact that it has a higher number of closed blocks as a reason for a higher threshold – but those consumers are often subject to higher increases and need the highest levels of scrutiny. Similarly, a threshold based on state-specific medical costs and provider concentration may be circular: such a threshold would not encourage plans to negotiate more favorable provider rates nor to establish cost-containment measures. In these cases, it may be more appropriate to rely on a federal threshold.

The Discussion Draft also highlights deductible leveraging as a factor that could lend itself to a "direct mathematical adjustment" of the 10 percent threshold. But the 10 percent threshold apparently does not factor in national average deductibles that would allow such a direct adjustment. More importantly, with deductibles rising sharply, states could argue that the threshold requires an upward adjustment based on leveraging. With each rate increase, deductible leveraging factors in themselves should be closely scrutinized to prevent issuers from unnecessarily adding to the trend factor used. Average deductibles in a state or average deductible factors used by issuers should not be used as proposed.

HHS Must Encourage Aggressive Review

Finally, we have noted widespread reports of insurers requesting rate increases just below the 10 percent threshold. We urge CMS to ensure that the states understand that a rate increase below the threshold is not necessarily reasonable. Indeed, it may be unreasonable for an insurer to fail to reduce its rates if medical costs are declining. We urge CMS to use any future rate review grants to the states to encourage aggressive review of rates to ensure that all health insurance premiums are reasonable. In addition, the guidance on state-specific thresholds should make clear that states that currently review all rate increases regardless of threshold should continue to do so. CMS should maintain on a public website a list of which states are reviewing all rate increases, those reviewing only increases above the default threshold and those that are using thresholds established through a state-initiated process.

Thank you for your consideration.

Health Care for America Now
Consumers Union
National Women's Law Center
Service Employees International Union
Families USA
Community Catalyst
First Focus
American Cancer Society Cancer Action Network
Young Invincibles
Consumers for Affordable Health Care
Missouri Health Advocacy Alliance
Virginia Poverty Law Center
Southwest Women's Law Center
Maine People's Alliance
Maine Council of Churches
Health Action New Mexico
Maine Equal Justice Partners
UHCAN Ohio
Maine Women's Lobby
Center for Economic Justice
Colorado Consumer Health Initiative

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